Psychiatric Units in General Hospitals

Problems in Development and Efficient Operation

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• **An adequate 25-bed psychiatric unit can be housed in a wing of a general hospital. Even more important than physical facilities are competent personnel, to be headed by a chief psychiatrist and a psychiatric nurse supervisor, for the unit. Incorporating teaching facilities into the unit helps to integrate psychiatry into the other disciplines of medicine in a continuing educational program.**

Having psychiatric units in general hospitals enables many voluntary patients to be treated in early stages of the disorder, with a high proportion of recoveries.

Medicolegal aspects and the lack of adequate coverage of mental disorders by voluntary prepayment health plans are serious problems in the economy of a unit. Improved hospital administration, expanded training programs, educational work by local mental health societies and modification of laws on malpractice and commitment will go far to help solve these problems.

THE PRACTICE of psychiatry in general hospitals began only about 35 years ago. At that time only a very few hospitals had psychiatric departments. Gradually the idea spread in the mid-West and East. By 1952, according to a survey made by the author and coworkers, of the 1600 larger hospitals in the United States, 205 had fairly adequate units of 15 beds or more, but only 129 of them were nongovernmental hospitals. Some general hospitals would admit a psychiatric patient briefly for emergency treatment or diagnosis, but at least half of the hospitals included in the survey did not admit a patient known to have a psychiatric disorder. We estimated that only about 20,000 of a total of 574,638 general hospital beds were available for psychiatric patient care—or about a third of the 60,000 beds considered a minimum need.

A book, "The Practice of Psychiatry in General Hospitals,"[1] contains the responses to the survey and to various articles on the topic. The book deals with the major problems connected with setting up and operating psychiatric departments. The study convinced me that every general hospital should offer some kind of psychiatic service. Adequate psychiatric facilities within general hospitals would attain the following results: (1) Shorten hospitalization and improve the quality of recovery; (2) prevent needless diagnostic and treatment expenses, on the basis that at least a fourth of all general hospital patients have psychiatric problems; (3) relieve state hospital overcrowding; and (4) improve public satisfaction with medicine and with hospitals and thus improve the general community health.

Since the already mentioned preliminary survey, the number of psychiatric units in general hospitals has expanded greatly. There are now more than 600. Patients previously excluded from general hospitals because of mental illness, alcoholism or drug addiction are being admitted in increasing numbers.

The organization and operation of such units present many special problems, some of which may be unfamiliar to administrators, psychiatrists or other medical personnel who have not had first hand experience in these departments.[2]

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Planning and Staffing

Architectural and technical details are well covered in several excellent books and U. S. Public Health Service pamphlets. Personal experience permits me to say that an adequate 25-bed psychiatric department can be housed in an ordinary hospital wing, without prohibitive cost for remodeling. Sections for men and women need not be separate. Semiprivate rooms and small wards are better than private rooms; they facilitate group adjustments. Some space is essential for day rooms and for dining, occupational and recreational areas. Also needed are special interview, treatment, nursing and utility rooms. Soundproof, air-conditioned seclusion rooms are usually needed in a ratio of one for about every 20 patients. A combination of open and closed departments, with areas for daytime patients, is an ideal arrangement. A 25-bed department headed by a psychiatric nurse supervisor can function with such minimum personnel as one graduate psychiatric nurse, an assistant nurse or two senior student nurses, and two aides (a male and a female) for each 8-hour shift. Other needed personnel include an occupational and recreational therapist and, part-time a clinical psychologist and a psychiatric social

worker. It is of great help to the psychiatrists who treat the patients to have the services of two psychiatric residents and one intern who can receive their graduate training in an accredited department.

In planning a psychiatric unit in a general hospital, it is extremely important to convince hospital administrators of the desirability and value of such a department. Some administrators believe that disturbed patients pose hazards of suicidal and homicidal behavior, or at least may be too noisy. Others object to the possibility of the long term use of beds for patients found to need protracted care or observation. Some believe that psychiatric departments will not pay their way. However, the great majority of administrators with any experience with these departments stress their great advantages.

Increasing appreciation of the role of emotional factors in many diseases has made the general hospital the proper, necessary place in which to teach psychiatry and conduct research. Here medical students, young physicians and nurses see psychiatry in its proper perspective and learn the importance of emotions causing or contributing to many illnesses besides the frank psychoneurotic or psychotic disorders.

Plans for Teaching Facilities in Psychiatric Units

A series of seminars should be held by the psychiatric staff to explain psychiatric methods to the nonpsychiatric administrative, medical and nursing staff. These discussions should center on such matters as rules of the department, types of patients to be admitted, methods of admission and voluntary admissions. Treatment methods for psychiatric patients requiring care in closed wards should be distinguished from the methods needed for patients having psychosomatic disorders. The management of suicidal patients should be explained, as should the occasional advisability of transferring from other departments patients with organic disease who show mental symptoms—for example a surgical patient who becomes delirious. The psychiatric nurse should take up the importance of correct charting of behavior and the various methods of psychiatric nursing. The hospital resident and intern staff should be instructed in the technique of interviewing not only patients but relatives. Considerable discussion of the problem of dealing with relatives and visitors in the department should be carried out. A manual regarding rules of the department, elementary aspects of mental illness and procedures in treatment should be given to relatives to help alleviate their concern.

A library to which physicians and nurses can refer concerning psychiatric problems is an important aid in the teaching program. Selected lists of pamphlets approved by the National Committee of Mental Hygiene and the reports of the Group for Advancement of Psychiatry should be incorporated in the library section. A separate library for patients has proved to be a very valuable aid in therapy, and special books are often prescribed by the attending psychiatrist according to the individual needs of the patient.

After the department is organized and functioning, regular weekly seminars should be continued by various attending physicians to discuss histories, diagnoses, nursing problems and special therapies. These seminars are attended by nurses, interns and residents. Monthly departmental meetings of the active staff to discuss problems that arise are mandatory. Special staff clinics should include various psychiatric problems to help orient the nonpsychiatric practitioner and show the value of psychiatric therapy. In short, all means possible should be employed to integrate psychiatry into the other disciplines of medicine in a continuous educational program.

The Staff

The most important step in establishing a department is to obtain competent psychiatric personnel. First, a chief psychiatrist or organizing committee, preferably with general hospital experience, should be given the responsibility of organizing the professional and nursing staff and integrating the unit within the general hospital.

No practitioner who is not fully qualified by training should be permitted to care for psychiatric patients. Board eligibility or certification in psychiatry is the usual criterion for staff membership. Rules and regulations, uniform and strictly adhered to, must include all nursing problems. They make the nurses' work interesting, instructive and efficient.

Physicians in other departments should have access to the unit, in order to treat patients with delirium and complicating medical and surgical diseases, but patients whose disease is entirely psychiatric should be referred to the psychiatrist. The problem of visitors is an important one. We have found from experience that as a rule patients should have visitors only by special permission of the psychiatrist in attendance. Often the influence of visitors leads to dissatisfaction of the patient and to premature dismissal, or raises other problems that interfere with adequate therapy.

Therapy

One of the advantages of having psychiatric units in general hospitals is that patients come in voluntarily for early treatment in the acute stage of a disorder. Treatment at this stage tends to prevent chronicity, and 80 per cent of patients are returned to the community within a few weeks. Most persons,

given a choice, would rather have swift, early treatment for psychiatric disabilities in general hospitals, than the often difficult procedure of commitment to a state hospital.

As soon as psychiatric units are established in general hospitals, the incidence of consultations between other specialties in medicine and psychiatry goes up, which greatly helps the integration of psychiatry with other departments in the hospital. The biggest problem, that of overcoming prejudice against mental illness, requires education of a board of directors, of the medical staff and of the general public. Acceptance of psychiatry in general hospitals is one of the most valuable means of overcoming misconceptions and prejudices about mental illness.

Conditions found to be favorable to treatment in general hospitals include the severe neuroses, the psychosomatic disorders, all the toxic psychoses, acute major breakdowns such as depressions and excitements, alcoholism and drug addictions. The gravest problems in treatment are the schizophrenic patients. Patients with acute schizo-affective disorders can usually be straightened out in a few weeks' treatment, but those with more chronic types usually have to be transferred to the state hospitals.

At present we hear much about the concept of the therapeutic community or the open hospital, a concept that will grow. The major trends are for more and more open hospitals or therapeutic communities, which in turn create the need for greatly increased community rehabilitation services. Klapper's[3] list of 23 rehabilitation centers that admit ex-mental patients includes Herrick Memorial Hospital, in Berkeley. These patients, who make up about 2 per cent of the entire load, come from our 46-bed psychiatric unit and outpatient clinic; eventually the two will be coordinated. This trend means an increased, closer relationship of the general hospital with the community. The need is for integration of the general hospital as the true community hospital, and direction of the total program in the interest of the whole person, regardless of his type of illness.

A.M.A. Council Recommendations

The recent conference of mental health representatives of the state medical associations sponsored by the American Medical Association's Council on Mental Health agreed on these recommendations:

1. All new construction should provide community mental health centers and general hospital facilities for the psychiatric patients—not large public mental hospitals.

2. State medical societies should be encouraged to study ways to close the gap between organized medicine and the public mental hospital.

3. Private psychiatric hospitals should encourage staff relationships similar to those in general hospitals.

4. The psychiatric units of the general hospitals should function in terms of community needs and provide effective treatment for psychiatric emergencies.

5. Members of the staff of outpatient psychiatric clinics should improve their relationship with other physicians, especially with the referring physician.

6. The community must share in the responsibility of accepting the well patient back into its social life.

7. Mental health committees of state medical societies should set up widely representative groups to study the Uniform Mental Health Act as a basis for preparing a mental health bill acceptable to the state. The state medical societies should take up the problem and make recommendations.

Problems in Adequate Functioning of a Department

A few departments established in various parts of the United States have been abandoned after some months or years of operation. In general, the reasons have been problems in economics, medicolegal problems and poor communication between psychiatry and the general medical staff and administrative boards of the hospitals.[2]

Most of these problems can be solved by anticipating them: A special committee made up of representatives of the psychiatric staff, the nursing staff and the administrative staff of the hospital should be responsible for the necessary rules and regulations for the department's operation. In some instances, legal opinions concerning certain legal responsibilities of the hospital and general management of the department may be needed.

Medicolegal Problems

Malpractice problems are a most serious deterrent to the organization of psychiatric units in general hospitals. Far too many unjustified suits have been brought against psychiatrists in recent years. This problem seriously affects all medical practice. In one instance, a San Francisco hospital, because of legal opinions concerning potential malpractice problems, abandoned a plan that had been worked out for a psychiatric unit and otherwise approved. Accidents to psychiatric patients under treatment do constitute a risk. A paranoid patient, for example, can almost always find a way to start suit against a physician or a hospital. The American Psychiatric Association's standing committee on private practice should study this problem and cooperate with the parallel committee of the American Medical Association to obtain adequate legal protection. Many unjustified suits are settled out of court by insurance companies to avoid the expenses of trial.

Interpretations of the doctrine of *res ipsa loquitur* in California courts have so perverted the law that virtually the burden rests not upon the plaintiff to prove malpractice but upon the defendant physician to prove he acted competently.

Health Insurance

A further deterrent to successful operation of a psychiatric unit in general hospitals is the discrimination against psychiatric treatment by many Blue Shield and Blue Cross voluntary prepayment health insurance plans. Without uniform coverage through the voluntary prepayment insurance plan for all patients sick enough to require treatment in an accredited hospital, the increasing costs of psychiatric treatment will hamper the development of these units in general hospitals. Families have to make severe financial sacrifices to keep patients under treatment, even though the average stay is less than 30 days. Definite improvement has taken place in that 77 per cent of Blue Cross and Blue Shield plans throughout the country at the present time give some psychiatric coverage. However, Blue Shield plans in California still provide no such coverage. On the other hand, the successful Cleveland plan, probably the most progressive in the country, for 20 years has included psychiatric treatment without increasing the cost to the insured.[5]

In New York a two-year experimental program, Group Health Insurance, Inc., jointly sponsored by the National Association for Mental Health and the American Psychiatric Association, has a sample group of 75,000 persons who will be eligible for mental health coverage without increased premiums.[7] Actuarial data will be compiled. Weil stated that it is actuarily possible to include short-term hospitalization for mental illness with a 2 or 3 per cent increase in premiums.[6]

It must be pointed out to insurance companies again and again that they already pay for many episodes of mental illness under subterfuge diagnoses; and we must help mental health organizations, industrial unions and other lay groups to bring about a public demand for the inclusion of mental illness in the prepayment voluntary health insurance plans.

Changes Needed for Future Development of General Hospital Psychiatry

Mental hygiene societies should take steps to educate communities to understand mental illness and the local needs for treatment. All hospitals should be urged to admit mental patients if only for diagnosis, consultation and transfer, without prejudice. The larger hospitals should incorporate psychiatric departments.

Expansion of training programs for residents, interns, nurses and vocational aides is a great need because of the tremendous shortage of professional personnel. Psychiatric experience should be a requirement of all internships.

Hospital administrators must learn to interpret the needs and values of psychiatric treatment and overcome existing medical prejudices. Administrators should help solve economic problems by obtaining effective, comprehensive prepayment health insurance, and should advocate measures to expedite early hospital treatment, with easy transfer to and from public hospitals, without court procedure.

Future psychiatric units must include open units in the architectural planning. The use of colors and modern furnishings provides cheerful environments, with no resemblances to a prison. The enlistment of volunteer workers, and such auxiliary workers as Alcoholics Anonymous, the incorporation of group therapy wherever practical and the use of a plan under which selected patients may go to the hospital during the day but return home each night, go a long way toward solving the financial problem. The development of an outpatient clinic to work with the inpatient department and the greater use of outpatient treatment facilities for cooperative patients serve to cut down the extreme costs of hospitalization. Future departments will have to pay more attention to the geriatric problems of the aging population. Too many of the elderly patients have been considered hopeless seniles, whereas many of them have toxic delirious reactions or affective disorders that respond promptly to treatment.

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